DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445111	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT STANDIFER PLACE, THE	2626 WALKER RD CHATTANOOGA, TN 37421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	**Tag: F159** 1. Resident or Legal Representative of Residents identified in the survey were contacted immediately and balances were spent down appropriately. Facility will no longer net the banking service fee with the interest paid. Facility will begin applying interest paid by bank to the Patient Trust account as paid by the bank. 2. Facility to review all other patient trust balances. If the Resident is within $200.00 of the SSI resource limit ($2000.00) the facility will facilitate appropriate use of funds to maintain Medicaid eligibility. Facility to include the application of interest as part of the month-end closing process. 3. Conduct an In-Service with partners in the Business Office who are involved with Patient Trust to re-educate them on the processes and procedures to ensure proper management of Patient Trust funds and on the application of interest to patient accounts. Inservice will be conducted by the Business Ofc. Dept. Head. 4. The Facility will conduct a QA study to ensure that Patient Trusts balances and application of interest are managed in accordance with Federal and State regulations. The QA study will be conducted by the Business Office Department Head. QA study will be quarterly as needed.	07/14/11 07/31/11 07/31/11 08/01/11 07/31/11 8/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glen Stramm — TITLE: Administrator — (X6) DATE: 8/1/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of resident trust accounts and interview, the facility failed to notify the responsible party of three residents who received Medicaid benefits when the amount in the resident accounts was within $200.00 of the SSI resource limit ($2,000.00), and failed to credit interest to 303 of 303 resident accounts reviewed. The findings included: Review of three resident trust accounts revealed the following balances: account #1 on June 3, 2011=$1,935.77, July 1, 2011=$2,825.77, and July 13, 2011=$1,925.77; account #2 on May 6, 2011=$1,844.99, June 6, 2011=$1,894.99, and July 13, 2011=$1,944.99; account #3 on May 6, 2011=$1,809.79, June 6, 2011=$1,860.19, and on July 3, 2011=$1,910.59. Review of 303 resident trust accounts revealed a balance of $154,375.01 on July 13, 2011. Continued review of the 303 resident trust accounts revealed no interest was applied to the accounts from January 1, 2011, through June 30, 2011. Interview on July 13, 2011, at 8:35 a.m., with the	F 159		

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F 159	Continued From page 2 bookkeeper, in the bookkeeper's office, revealed the social worker was to be notified when resident's receiving Medicaid benefits trust accounts approached $2,000.00, to notify the resident or the responsible party. Continued interview with the bookkeeper confirmed there was no interest applied to the resident trust accounts from January 1, 2011, through June 30, 2011. Interview on July 13, 2011, at 9:50 a.m., with social workers #1 and #2, in the conference room, confirmed the resident or responsible party of the three Medicaid residents with account balances within $200.00 of the SSI resource limits had not been notified.	F 159	**Tag: F160** 1. Resident or Legal Representative of Resident identified in the survey was contacted and balances were refunded immediately. 2. Facility will review accounts to ensure appropriate disbursement of funds for discharged residents. 3. Conduct an In-Service with partners in the Business Office who are involved with Patient Trust to re-educate them on the processes and procedures to ensure proper management of Patient Trust funds. 4. The Facility will conduct a QA study to ensure that Patient Trust balances are managed in accordance with Federal and State regulations. The QA study will be conducted by the Business Office Department Head.	07/13/11 07/13/11 07/15/11 8/27/11 ADM/VF 3rd Quarter of 2011 & Ongoing
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of resident trust accounts, facility policy review, and interview, the facility failed to refund the balance of the resident trust accounts,within 30 days, after the discharge or death for two (#32, #33) of five closed records reviewed. The findings included:	F 160		

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F 160	Continued From page 3 Medical record review of the nursing notes revealed resident #32 was discharged to the hospital on October 28, 2010. Review of resident #32's trust account revealed a balance of $1,860.11 on July 13, 2011. Medical record review of the nursing notes revealed resident #33 expired on October 2, 2010. Review of resident #33's trust account revealed a balance of $1,876.72 on July 13, 2011. Review of the facility's policy Patient Trust revealed "The balance remaining for a patient's trust fund account should be refunded as soon as all transactions are fully accounted for after a patient is discharged or deceased...The funds should be refunded within 30 days of death or discharge..." Interview on July 13, 2011, at 8:35 a.m., with the bookkeeper, in the bookkeeper's office, confirmed the balance of resident #32 and #33's trust accounts had not been refunded to the residents' estate.	F 160	**Tag: F167** 1. Copy of the most recent survey was placed in the Dalton Place building Main lobby so that it is readily accessible to all residents of the building. 2. Administration will ensure the postings in both buildings are maintained at all times via assigned rounds. 3. Administration and Department Heads were inserviced on the requirement that the survey be posted in both buildings. 4. Administration will ensure the postings in both buildings are maintained at all times via assigned rounds.	07/19/11 Ongoing 07/15/11 8/27/11 Ongoing Dupe adm request DF
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of	F 167		

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F 167	Continued From page 4 their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to make available the survey results in one of the two facility buildings. The findings included: Observation on July 13, 2011, at 10:50 a.m., with a Registered Nurse (RN #3) for the East 200 hall, revealed a sign posted in the main lobby of the Dalton Building which stated the latest survey results could be located in the main lobby of the Hamilton building and the main lobby of the Dalton building. Continued observation revealed the survey results were not located in the main lobby of the Dalton building. Interview with the Registered Nurse (RN #3) on July 13, 2011, at 10:50 a.m., in the main lobby of the Dalton building, confirmed the survey results were not available in the main lobby the Dalton building as directed by the sign.	F 167	**Tag: F226** 1. The facility's Abuse policy has been changed to read. "Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take the necessary corrective actions depending on the results of the investigation". 2. The facility will continue to identify, investigate, protect, report and respond to suspicious bruising, occurrences, patterns and trends that may constitute abuse as well as reports of abuse. The Administrators and DON will monitor that the facility's Abuse policy is implemented correctly and completely by reviewing all identified and alleged abuse investigation completed by the ADON/Risk Management Nurse. The Administrators, DON and other Nursing Management will participate in fact finding when necessary. The ADON will inform the Administration of any identified, suspicious or alleged abuse. 3. The facility will conduct an in-service for Facility staff in regards to "Abuse Policy and Procedure". This in-service will be conducted by the Staff Development Coordinator, ADON and Head Nurses. The in-services will be conducted during the weeks between July 25 and August 12, 2011. 4. The facility will conduct a quarterly Quality Assurance/Improvement audit regarding "Abuse Policy and Procedure" by interviewing at least 4 facility staff members on each unit as well as observe for any suspicious bruising, occurrences, patterns or trends during Nursing Administration's "In Search of Excellence" floor audits. The audit will be conducted prior to the end of 3rd quarter 2011. The audit will be conducted	07/22/11 07/14/11 08/12/11 8/27/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		

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F 226	Continued From page 5 Based on facility policy review, and interview, the facility failed to ensure the Abuse policy revealed all allegations of abuse, substained or not, were to be reported to the state agency. The findings included: Review of the facility Abuse policy revealed, "...Any investigation that substantiates abuse or neglect will be reported immediately to the administrator or his designated representative and to other officials in accordance with State Law within 5 working days of the event. A report is filed with the state survey and certification agency, and any other required agencies..." Interview on July 13, 2011, at 8:30 a.m., with the Assistant Director of Nursing, in the Social Worker's office, confirmed the abuse policy did not reveal all allegations of abuse, substained or not, were to be reported to the state agency, and confirmed the abuse policy did not correspond with the federal regulations.	F 226	by the DON and/or ADON. Staff Development Coordinator. MDS Nurse Supervisor. Falls Prevention Nurse and Clinical Record Compliance Nurse. The results of this audit will be presented to the QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators. Medical Director. Director of Nursing. Asst Director of Nursing. Clinical Record Compliance Nurse. Dieticians. Rehab Director. Social Service Directors. Food Service Director. Falls Prevention Nurse/Coordinator. Housekeeping Directors. Laundry Director. Bookkeeping Director. and other staff invited to observe and participate.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 246		

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F 246	Continued From page 6 and interview, the facility failed to place the call light within reach for one (#10) of thirty-four residents reviewed. The findings included: Resident #10 was admitted to the facility on May 5, 2011, with diagnoses including Left Shoulder Fracture, Adult Failure to Thrive, Atrial Fibrillation, and Hypertension. Medical record review of the Minimum Data Set dated May 12, 2011, revealed the resident was able to make self understood and did not walk. Observation on July 11, 2011, at 9:58 a.m., revealed resident #10 sitting in the wheelchair, beside the resident's bed. Continued observation revealed the resident stated "I'm about to faint," wanted to be assisted to bed, and was unable to locate the call light. Continued observation revealed the call light cord extended under a blanket to a side rail behind the resident's wheelchair. Observation and interview on July 11, 2011, at 10:01 a.m., with Licensed Practical Nurse (LPN) #3, in the resident's room, confirmed the call light was not within the resident's reach.	F 246	**Tag: F246** 1. Resident # 10 call light was immediately placed back within reach of patient upon discovery by Nurse and surveyor. The CNA had just gotten resident OOB and when she lowered side-rail. the call light was attached and lowered as well. The resident's shortness of breath was assessed. Her O2 saturation was 94%. Nursing also requested Respiratory therapy assess resident. Resident normally has O2 saturations around 93%. The CNA responsible for lowering side-rail and not placing call light within reach of resident will be re-educated and counseled.	07/11/11
			2. The facility will continue to accommodate the needs of the residents by placing call lights within reach of residents at all times while resident is in their room. Call light placement will be monitored through daily observation of care rounds by Head nurses & Supervisors.	7/14/11
			3. The facility will conduct an in-service for Facility staff in regards to "Accommodation of Resident's Needs: Call Lights". This in-service will be conducted by the Staff Development Coordinator. ADON and Head Nurses. The in-services will be conducted during the weeks between July 25 and August 12, 2011.	08/12/11
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253	4. The facility will conduct a quarterly Quality Assurance/Improvement audit regarding "Accommodation of Resident's Needs: Call Lights". This study will be conducted during Nursing Administration's "In Search of Excellence" floor audits. Resident's call light placement will be assessed during the environmental portion of the audit on each floor. Call Light placement will	8/27/11

Tag 246: The Health Center at Standifer Place #445111

also be audited during the Environmental walk-through done by Nursing Administration each month. These audits will be conducted by the DON and/or ADON. Staff Development Coordinator. MDS Nurse Supervisor. Falls Prevention Nurse and Clinical Record Compliance Nurse. The results of this audit will be presented to the QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators. Medical Director. Director of Nursing. Asst Director of Nursing. Clinical Record Compliance Nurse. Dieticians. Rehab Director. Social Service Directors. Food Service Director. Falls Prevention Nurse/Coordinator. Housekeeping Directors. Laundry Director. Bookkeeping Director. and other staff invited to observe and participate.

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F 253	Continued From page 7 by: Based on medical record review, observation, and interview, the facility failed to ensure resident care equipment was in good repair for one (#16) of thirty-four residents reviewed. The findings included: Resident #16 was admitted to the facility on October 1, 2008, with diagnoses including Diabetes, Hypertension, and Bilateral Above the Knee Amputation. Medical record review of the Safety/Positioning/Protective Equipment Documentation dated June 1, 2011, revealed, "...Side rails with pads... pads which protect skin integrity for residents with movement disorders or neurological diseases...pt (patient) moves in bed (and) hits extremities on rails..." Observation on July 12, 2011, at 7:50 a.m., with Registered Nurse #2, revealed the resident lying on the bed with rail pads in place. Continued observation revealed the rail pad on the resident's left side torn at the top with the pressed board exposed. Interview on July 12, 2011, at 7:50 a.m., with Registered Nurse #2, in the resident's room, confirmed the rail pad was in need of repair.	F 253	**Tag: F253 The Health Center at Standifer Place #445111** 1. The torn bumper pad with the exposed wood being used on Resident # 16 bed observed during initial walk-through was removed and replaced immediately by the Head Nurse. — 07/11/11 2. The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment. An assessment of the facility's resident care equipment will be conducted to assure that it is in good repair and operating safely. Resident care equipment is observed and assessed daily by all staff who provide direct care as well as nursing Supervisors or any others who enter patient care areas. Equipment found in ill-repair or not to be operating safely will be removed from Resident area until such repairs can be made. Monthly environmental rounds will be conducted by the Administrators, DON, and other members of management as designated, and will include equipment observations. — 7/14/11 3. The facility will conduct an in-service for Facility staff in regards to "Equipment Maintenance". This in-service will be conducted by the Staff Development Coordinator, ADON and Head Nurses. The in-services will be conducted during the weeks between July 25 and August 12, 2011 — 08/12/11 4. The facility will conduct a quarterly Quality Assurance/Improvement audit regarding "Resident care Equipment". This study will be conducted during the Nursing Administration's "In Search of Excellence" floor audits. Resident care equipment will be observed during the environmental portion of the audit on each floor. Equipment that is in ill-repair or does not appear to be working properly — 8/27/11
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

Tag: 253: The Health Center at Standifer Place #445111
will be removed immediately from resident care area. Maintenance or the necessary vendor will be notified so repairs can be scheduled and made. This audit will be conducted prior to the end of the 3rd quarter of 2011. This audit will be conducted by the DON and/or ADON. Staff Development Coordinator. MDS Nurse Supervisor. Falls Prevention Nurse and Clinical Record Compliance Nurse. The results of this audit will be presented to the QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators. Medical Director. Director of Nursing. Asst Director of Nursing. Clinical Record Compliance Nurse. Dieticians. Rehab Director. Social Service Directors. Food Service Director. Falls Prevention Nurse/Coordinator. Housekeeping Directors. Laundry Director. Bookkeeping Director. and other staff invited to observe and participate.

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F 278	Continued From page 8 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS) for two residents (#34 and #14) of thirty-four residents reviewed. The findings included: Medical record review of a nursing note dated March 25, 2011, revealed resident #34 experienced a fall without injury on March 24, 2011.	F 278	**Tag: F278** 1. Resident # 14 and #34 MDS Section J1800 has been corrected to reflect accurate coding of fall/s. The MDS Nurse/s whom was responsible for the miscoding Section j1800 of the MDS will be re-educated. 2. The facility will conduct initial and periodic comprehensive assessments that are accurately coded for each Resident's functional capacity. The MDS Nursing team will review all resident's assessments that have fallen in the past 180 days to assure the accurate coding of section J1800 on the MDS. The MDS Nurse Supervisor will monitor the accuracy of the MDS Nurses completed assessments prior to the locking. transmitting and the MDS Coordinator signing. 3. The facility will conduct an in-service for MDS Nurses in regards to "Accurate Coding of Falls Section J1800 of MDS". This in-service will be conducted by the MDS Nurse Supervisor and MDS Coordinator. This in-service will be conducted during the week of July 25 – 29, 2011. 4. The facility will conduct a Quality Assurance/Improvement audit regarding "Accurately Coding Falls Section J1800 of MDS". This study will be conducted quarterly during Nursing Administration's "In Search of Excellence" floor audits. Ten resident's clinical records on each unit will be audited. This audit will include review of the MDS for accurate coding of falls in Section J1800. The audit will be conducted by the ADON. MDS Nurse Supervisor. Clinical Record Compliance Nurse. Falls Prevention Nurse and Staff Development Coordinator. More frequent	08/27/11 07/22/11 07/29/11 8/27/11

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	445111	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT STANDIFER PLACE, THE	2626 WALKER RD CHATTANOOGA, TN 37421

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F 278	Continued From page 9 Medical record review of the MDS dated April 26, 2011 did not indicate resident #34 had experienced a fall without injury. Interview with the MDS Coordinator, LPN #6, on July 13, 2011 at 11:05 a.m., in the Hamilton building conference room, confirmed resident #34's Minimum Data Set was inaccurate regarding the number of falls since admission or since the prior MDS assessment. Medical record review of resident #14 of the nursing note dated April 13, 2011, 4:50 p.m. revealed "...Resident was being assisted to bed. PT (patient) sat on side of bed before CNA (Certified Nurse Aide) could reposition backwards PT shifted and slid to floor...No injury noted..." Review of the Minimum Data Set (MDS) dated May 4, 2011, revealed the resident had not sustained a fall since the prior assessment dated February 16, 2011. Interview with the Minimum Data Set Coordinator (LPN #6) on July 13, 2011, at 10:40 a.m., in the lobby, confirmed the May 2011 MDS failed to address the fall sustained on April 13, 2011.	F 278	**TAG 278; The Health Center at Standifer Place #445111** studies will be conducted, if necessary based on the outcome of the original study. The study will be conducted sometime before the end of the 3rd quarter of 2011. The results of this audit will be presented to QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietician, Rehab Director, Social Service Directors, Food Service Director, Falls Prevention Nurse/Coordinator, Housekeeping Director, Central Supply Director, Laundry Director, Bookeeping Director and other staff invited to observe and participate.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities,	F 322		

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F 322	Continued From page 10 and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a tube feeding was administered as ordered for one (#3) of thirty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on February 24, 2011, with diagnoses including Chronic Respiratory Failure, Cerebral Palsy, Brain Injury, and Anemia. Medical record review of a physician's order dated July 8, 2011, revealed, "...(increase) goal rate on TF (tube feeding) to 75ml/hr (milliliters/hour) (with) free (water) flush 50ml/hr..." Observation on July 11, 2011, at 10:30 a.m. with RN (Registered Nurse) #1, and LPN (Licensed Practical Nurse) #4 revealed the resident seated in a reclined wheelchair, in the resident's room, with the tube feeding connected to the resident and the tube feeding not infusing. Continued observation revealed the tube feeding bottle was dated July 11, 2011, 12:30 a.m., with 1500 milliliters of Jevity 1.2 in the bottle. Continued observation revealed the tube feeding pump displayed a feed error. Interview on July 11, 2011, at 10:30 a.m., with RN #1 and LPN #4, in the resident's room, confirmed	F 322	**Tag: F322** 1. Resident # 3 had knocked over her feeding pump several times during the night. The pump was reading "error" when the surveyor observed the pump during initial walk-through and it appeared that Resident # 3 had not received the correct amount of feeding during the night. Nursing requested that the Dietician assess Resident and place Resident on bolus feedings to prevent Resident from interrupting her feeding by knocking over pole and pump. Resident was placed on bolus feeding and the continuous feeding was discontinued per Dietician and Physician's order. Resident had not experienced any significant weight loss. 07/11/11 2. The facility will assure that Residents who are tube fed via gastrostomy tube receives the appropriate treatment and services. assessment for complications from tube feedings as well as prevent significant weight loss and restore. if possible. normal eating skills. The facility's Dieticians will monitor weights per facility policy and address weight loss by implementing new care planned measurable approaches. The facility's Nursing administration will monitor Tube feeding administration through observation of care rounds. These rounds will be conducted monthly by the DON. ADON, and other members of the Nursing and Dietary Management team as designated. 07/29/11 3. The facility will conduct an in-service for Nursing staff in regards to "Tube Feeding Administration". This in-service will be conducted by the Staff Development Coordinator, Dieticians and Head Nurses. The in-services will be conducted during the weeks between 7/25/11 & 8/12/11. 08/12/11 4. The facility will conducted a Quality Assurance/Improvement audit regarding	

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F 322	Continued From page 11 the resident had not received the tube feeding as ordered.	F 322	"Tube Feeding Administration" quarterly. This study will be conducted during the Nursing Administration's "In Search of Excellence" floor audits. All residents who are being fed via of a gastrostomy tube will be reviewed to assure that the resident is receiving the correct amount of tube feeding according to physician's order. The pump setting and hang times will be observed on each resident's feeding pump to determine accurate delivery of feeding. More frequent studies will be done, if necessary based on the outcome of the previous studies.This audit will be conducted by the DON and/or ADON, Staff Development Coordinator, MDS Nurse Supervisor, Falls Prevention Nurse and Clinical Record Compliance Nurse. The results of this audit will be presented to the QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Asst Director of Nursing, Clinical Record Compliance Nurse, Dieticians, Rehab Director, Social Service Directors, Food Service Director, Falls Prevention Nurse/Coordinator, Housekeeping Directors, Laundry Director, Bookkeeping Director, and other staff invited to observe and participate.	8/27/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain sanitary dietary equipment; and failed to maintain an ice machine lid in good repair. The findings included: Observation of the Hamilton dietary department on July 11, 2011, beginning at 10:00 a.m., with the Director of Operations present, revealed the following: 1.) Eight stacks of crates containing individual milk cartons, gallons of milk and five pound containers of yogurt were directly stored on the walk-in refrigerator #2 floor. 2.) A plastic covered large floor mixer. After removal of the plastic cover, the underside of the beater arm, base and bowl arm had multi-colored dried splattered debris present 3.) A plastic covered mid-size floor mixer. After	F 371		

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F 371	Continued From page 12 removal of the plastic cover, white dried debris splatters were present on the underside of the beater arm. 4.) A wall mounted fan by the trayline blowing directly onto a staff member rolling clean silverware in napkins and another staff member placing food into the steam table. Observation of the trayline fan grate and blades revealed an accumulation of blackened debris present. 5.) A wall mounted fan was blowing from the soiled side of the three compartment sink toward the clean side of the compartment sink and toward the clean side of the dish machine. Observation revealed soiled pots and utensils were stacked to be cleaned; clean dishes were coming out of the dish machine and clean utensils and pans were drying on the drying board of the three compartment sink. Observation of the dish room fan grate and blades revealed an accumulation of blackened debris present. Interview in the Hamilton dietary department on July 11, 2011, beginning at 10:00 a.m., with the Director of Operations, present during the observations, confirmed the crates containing individual milk, gallons of milk and yogurt were stored directly onto the floor of the walk-in refrigerator. Further interview confirmed the plastic covered large and small mixers had dried splattered debris present. Further interview revealed the plastic cover meant the equipment was clean and ready for use. Further interview confirmed the wall mounted fans were blowing into clean areas and the fan grate and blades were not clean. Observation on July 12, 2011, at 8:15 a.m. of the Dalton dietary department, with the Director of	F 371	**Tag: F371** 1. No residents were affected by the deficient practice(s). 2. No other residents had the potential to be affected by the deficient practice(s). 3. A) Walk-in refrigerator #2 all milk crates/milk products have been removed from the floor and placed 12" off of the floor. Facility will add dunnage racks to the cooler for future storage of the milk products. B) Large Floor mixer was immediately cleaned during survey. Mixer will be placed on a continual cleaning schedule and staff using the equipment will be re-trained on the proper cleaning of the equipment. C) Small Floor mixer was immediately cleaned during survey. Mixer will be placed on a continual cleaning schedule and staff using the equipment will be re-trained on the proper cleaning of the equipment. D) Wall mounted fan by trayline was taken down and cleaned immediately during survey. Fan will be placed on a routine cleaning schedule to guarantee the fan to be free of dust and debris. E) Wall mounted fan above potsink was taken down and cleaned immediately during survey. Fan will be placed on a routine cleaning schedule to guarantee the fan to be free of dust and debris. Fan will be re-mounted to blow away from the clean side of the pot washing area. F) Ice machine lid (Dalton Place Entry) – facility will replace lid of ice machine. Preventative maintenance will audit for future discrepancies & issues with machine. An out of order sign placed on machine till door is replaced. 4. Food and Nutrition Managers will continually visually audit aforementioned	07/11/11 07/11/11 07/12/11

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F 371	Continued From page 13 Operations present, revealed an ice machine in the entry area of the department. Further observation revealed the ice machine lid was broken exposing the insulation. Interview with the Director of Operations on July 12, 2011, at 8:15 a.m., revealed the entry area of the dietary department contained an ice machine used by nursing. Further interview confirmed the ice machine lid was broken exposing the insulation.	F 371	items to ensure sanitary compliance, staff will be re-trained, cleaning schedules updated, and employees will be documented for non-compliance. Items 1, 2, 3, 4 all discrepancies completed during survey. Ice machine lid will be ordered as soon as distributer finds replacement. Waiting for quotes for dunnage racks for milk cooler. order will be placed at that time.	8/27/11 and Ongoing Changed per adm. request VF
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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F 431	Continued From page 14 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility record review, facility policy review, and interview, the facility failed to ensure a system of reconciliation of narcotic medication patches in place on residents for a continual seventy-two hour period for 15 of 18 residents who used narcotic patches. The findings included: Medical record review with the Director of Nursing (DON) in the lobby area on July 12, 2011, at 9:30 a.m., of the facility's Medication Administration Records (MAR), for 15 of the 18 residents who require the use of narcotic patches for a continual seventy-two hour period, revealed there was no documentation to ensure continued presence and integrity of the narcotic patches during the continual seventy-two hour period the narcotic patch was on any the 15 residents. Interview with the Director of Nursing (DON) in the lobby area on July 12, 2011, at 9:30 a.m., confirmed there was no documentation of reconciliation of the narcotic patches during the continual seventy-two hour period the narcotic patchs were utilized by the 15 residents.	F 431	**Tag: F431** 1. The facility reviewed the documentation of "narcotic reconciliation monitoring" for 18 residents who were using a narcotic patch and found that only 3 patches were being monitored during the time between the every 72 hour application span. The facility added the observation of Narcotic patches every 8 hours between the 72 hour application span to the 15 Medication Administration Records to include the observation of Narcotic patches every 8 hour between the 72 hour application span. This review and correction to the MAR was accomplished prior to surveyors exiting building on 7/11/11. All patient's narcotic patches are now being observed/reconciled every 8 hours between applications. 2. The facility will maintain a system that will account for receipt, usage, disposition and reconciliation of all controlled medications. The system will include record of usage, disposition and reconciliation (counting, destruction, wastage, returned to pharmacy, disposal) of all controlled medication. Nurses will reconcile controlled medication with the passing of narcotic keys as well as observe/reconcile narcotic patches for placement every 8 hours. Nurses will check placement of narcotic patches on the residents through visual inspection every 8 hours and verify this by their signature on the MAR. 3. The facility will conduct an in-service for Licensed Nurses in regards to "Narcotic Accountability and Reconciliation". This in-service will be conducted by the Clinical Record Compliance Nurse and the Staff Development Coordinator. This in-service will be conducted during the	07/11/11 07/14/11 08/12/11

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F 431	Continued From page 15 Review of the facility policy Controlled Medication Storage, undated and unnumbered, revealed "...at each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and the controlled substance accountability record...controlled medication storage, records and expiration dates are routinely monitor by (the consultant pharmacist during medication storage inspection)..." Interview with the facility's pharmacy consultant by phone on July 12, 2011, at 4:20 p.m., revealed the facility had "...not experienced any issues loss or discrepancies on seventy-two hour narcotic patches...pain control pumps containing narcotics are in use on residents within the facility...are maintained in resident room...are reconciled each shift..." Interview with the DON in the conference room on July 13, 2011, at 10:15 a.m., confirmed narcotic patches in use on a resident for a continual seventy-two hour period need to be reconciled as a seventy-two hour period is too long to wait to ensure the accountability and integrity of the narcotic patch. Continued interview confirmed 15 of the facility's 18 residents who were on continual seventy-two hour narcotic patches had not been monitored to ensure continued presence and integrity of the narcotic patches during the continual seventy-two hour period the patches were on the residents.	F 431	weeks between July 25 and August 12, 2011. 4. The facility will conduct a Quality Assurance/Improvement audit regarding, "Narcotic Accountability and Reconciliation of Narcotic Patches". Each resident's MAR will be audited to assure that each resident patch is being reconciled every 8 hours between applications. This study will be conducted monthly x 3 then quarterly x 3. This audit will be conducted by ADON. Clinical Record Compliance Nurse and Staff Development Coordinator. More frequent studies will be conducted, if necessary based on the outcome of the studies. The results of this audit will be presented to QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators. Medical Director. Director of Nursing. Assistant Director of Nursing. Dietician. Rehab Director. Social Service Directors. Food Service Director. Falls Prevention Nurse/Coordinator. Housekeeping Director, Central Supply Director. Laundry Director. Bookkeeping Director and other staff invited to observe and participate.	8/27/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 16 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 441	**Tag: F441** 1. The bottled water found stored on the floor by the surveyor during initial walk-through in Resident # 31 room was immediately removed from floor. outside of containers sanitized and placed on shelf. The water was brought in by the resident's family and placed on floor without staff knowledge. Family was educated by surveyor and staff that water could not be stored on the floor. 2. The facility maintains an infection control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility also monitors infections for nosocomial trends. The facility's Administration will monitor the infection control practices of the facility staff through daily observation of care and environmental rounds. These environmental rounds will be conducted by Administrators. DON. ADON. and other members of the Nurse Management team as designated. 3. The facility will conduct an in-service for facility staff in regards to "Infection Control". This in-service will be conducted by the Staff Development Coordinator and the Head Nurses. This in-service will be conducted during the weeks between July 25 and August 12. 2011. 4. The facility will conduct a Quality Assurance/Improvement audit regarding. "Infection Control" monthly on each unit during environmental rounds as well as quarterly during Nursing Administration's "In Search of Excellence" floor audits. This study will include the observation of each resident room as well as common areas on each	07/11/11 08/12/11 08/12/11 8/27/11

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F 441	Continued From page 17 facility policy review, and interview, the facility failed to ensure infection control practices were maintained to prevent contamination of resident supplies for one resident (#31) of thirty-four residents reviewed. The findings included: Medical record review revealed resident #31 was admitted to the facility on January 5, 2011, with diagnoses to include Persistent Vegetative State, Late Effect Head Injury, Tracheostomy, and Feeding Tube. Medical record review of the Minimum Data Set, dated June 23, 2011, revealed the resident was alert but in a persistent vegetative state; was totally dependent on staff for all activities of daily living, had all nutrition needs met by a feeding tube; and required the use of tracheostomy for breathing. Observation in the resident's room with the Respiratory Unit Manager and the Assistant Director of Nursing on July 11, 2011, at 10:30 a.m., revealed a note taped to the resident's feeding tube pump. Continued observation revealed the tape on the note discolored around the edges. Continued observation revealed "Use bottled water for tube feeding...family request..." Continued observation revealed five 1 gallon bottles of commercially packaged water stored on the floor in front of the sink. Continued observation revealed four of the bottles of water were unopened and one was ¾ empty. Review of the Physician's order, dated May 31, 2011, no time noted, revealed '...flush (feeding	F 441	unit. This audit will be conducted by DON and/or ADON, Clinical Record Compliance Nurse, MDS Nurse Supervisor, and Staff Development Coordinator. The results of this audit will be presented to QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietician, Rehab Director, Social Service Directors, Food Service Director, Falls Prevention Nurse/Coordinator, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.	

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F 441	Continued From page 18 tube) with 60 ml (milliliters) of water Q (every) hour..." Review of the facility policy Infection Control (number X-11, dated December, 1998) revealed "...Respiratory...Bedside Equipment...Items are used for an individual patient as long as the product remains intact and sanitary..." Interview on July 11, 2011, at 10:30 a.m., in the resident's room with the Respiratory Unit Manager and the Assistant Director of Nursing confirmed the bottled water stored on the floor in front of the sink was intended for patient use. Continued interview confirmed in order to prevent contamination and the spread of infection, patient supplies are not to be stored on the floor. Continued interview confirmed the bottled water stored on the floor was not in accordance with infection control practices.	F 441	**Tag: F513** 1. Resident # 11 Radiology (Doppler Study) report that was done as ordered but could not be found filed in the clinical record was replaced with a duplicate copy prior to the exit of the state surveyors on 7/12/11. The duplicate copy was sent to the facility via fax from the local portable x-ray company. This was an isolated incident of misfiling. 2. The facility will file in the resident's clinical record signed and dated reports of x-rays and other diagnostic services. The facility will log and track all x-rays and other services ordered by the physician and/or Nurse Practitioner to assure that the reports are completed. signed. dated and correctly filed in clinical record. This will be monitored by the Laboratory Services Coordinator and the Clinical Record Compliance Nurse on a no less than monthly basis. 3. The facility will conduct an in-service for Licensed Nurses and Unit Secretaries in regards to "Ordering and Filing Radiology and Lab Services Reports". This in-service will be conducted by the Staff Development Coordinator and ADON. This in-service will be conducted during the weeks between 7/25 & 8/12/11. 4. The facility will conduct a Quality Assurance/Improvement audit regarding "Ordering and Filing Radiology and Other Lab Services Reports". This study will be conducted quarterly during Nursing Administration's "In Search of Excellence" floor audits. Ten resident's clinical records on each unit will be audited for Ordering. Signed and Filing of Radiology and Lab services	07/12/11 08/12/11 08/12/11 8/27/11
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to insure the results of a Doppler Study was included in the medical record for one (#11) of thirty-four residents reviewed. The findings included: Resident #11 was admitted to the facility on July	F 513		

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	445111	A. BUILDING _____ B. WING _____	07/13/2011

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F 513	Continued From page 19 16, 2008, with diagnoses including Chronic Kidney Disease, Diabetes Mellitus, Type II, Hypertension, and Renal Failure. Medical record review revealed an order dated March 7, 2011, "...Doppler Study (L) (left) leg/ (L) foot - Dx. (diagnoses) of /DM (Diabetes Mellitus) Type II and Neuropathy..." Medical record review revealed no documentation of the results for the Doppler Study. Interview with Registered Nurse (RN # 3) on July 13, 2011, at 10:30 a.m., in the Dalton building conference room, confirmed the results of the Doppler Study were not made available in the resident's medical record.	F 513	reports. The audit will be conducted by the ADON, MDS Nurse Supervisor, Clinical Record Compliance Nurse, Falls Prevention Nurse and Staff Development Coordinator. The study will be conducted sometime before the end of the 3rd quarter of 2011. More frequent studies will be conducted, if necessary based on the outcome of the original study. The results of this audit will be presented to QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietician, Rehab Director, Social Service Directors, Food Service Director, Falls Prevention Coordinator, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview and	F 514		

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F 514	Continued From page 20 policy review, the facility failed to have documentation of the ordered blood pressure for one resident (#9); and failed to have documentation of interventions for asymptomatic episodes of blood sugars below 70 for one resident (#14) of thirty-four residents reviewed. The findings included: Resident #9 was admitted to the facility on January 4, 2008, with diagnoses including Diabetes Mellitus, and Hypertension. Medical record review of the June 2011, Current Physician Orders (Recapitulation) signed by the physician on July 8, 2011, revealed "...Lisinopril (hypertension medication) 10 mg (milligrams) tablet by mouth daily at 9:00 a.m.; take bp (blood pressure) on sundays call md (medical doctor) if sys. (systolic) outside 80 to 200 dias.(diastolic) outside 50 to 100 Start date 5/26/10...." Medical record review of the 2011, April, May, June, and July Medication Administration Records, the vital sign record, and the nursing notes revealed no documentation for eleven of fourteen opportunities to document the blood pressure on Sundays. Interview with Licensed Practical Nurse #2, on July 13, 2011, at 7:30 a.m., at the 800 hall nursing station, confirmed the 2011, April, May, June and July Medication Administration Records, nursing notes and the vital sign record did not contain documentation of the blood pressures.	F 514	**Tag: F514** 1. Nurse/s responsible for not documenting a Blood Pressure or Pulse on Resident # 9 Medication Administration Record when the medication being administered required one will be re-educated and counseled. The Head Nurse who was responsible for assuring the prompts for Blood Pressure and Pulse were in the Electronic MAR will also be re-educated and counseled. The resident did not experienced any adverse effects from the medications being administered. Resident # 14 was treated appropriately when her blood glucose was <70. but the nurse failed to document Resident's hypoglycemic symptoms or notify the physician. The Resident was treated according to protocol and responded well to treatment. The Nurse/s responsibly for failing to document in the Clinical record the resident's hypoglycemic symptoms and who also failed to notify the physician will be re-educated and counseled. 2. The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete: accurately documented, readily accessible and systematically organized. Records will contain sufficient information to identify resident. The facility will continue to assure that there is documented vital signs when the medication being administered requires one to be taken prior to or within 30 minutes of administration of medication as well as assure that the physician/NP is notified of all abnormal/panic value results so that prompt, appropriate action may be taken if indicated for the Resident's care.	08/27/11 07/29/11

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F 514	Continued From page 21 Resident #14 was admitted to the facility on January 5, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and Polyneuropathy. Medical record review of the physician orders revealed "...Novolog (insulin) 100 unit/ML (units per milliliters) Solution ...FOR BG (blood glucose) < (less than) 70 AND SYMPTOMATIC - GIVE GLUCAGON, 1 MG (MILLIGRAM) SUBQ (subcutaneously); IF ASYMPTOMATIC - MAY GIVE JUICE...Start Date: 10/25/2010..." Medical record review of the 2011 April Medication Administration Record (MAR) revealed at 7:30 a.m. on April 4 the BG was 63; and on April 13 the BG was 55. Medical record review of the 2011 May MAR revealed at 7:30 a.m. on May 1 the BG was 66, and on May 5 the BG was 55. Medical record review of the nursing notes revealed no documentation of any interventions addressing the low blood glucose. Review of the facility document "MD Standing Order" revealed "...Hypoglycemia...If BG <70, may give juice or sugar equivalent if patient able to swallow or if feeding tube in place...Document all treatments and results in Nurse's notes..." Interview with the Director of Nursing on July 12, 2011, at 10:35 a.m., by the 900 nursing station, confirmed on April 4, and 13, 2011; and May 1 and 5, 2011, the nursing notes did not contain documentation of intervention administered for BG less than 70 as ordered.	F 514	The Head Nurses for each unit will review the resident's medication administration records to determine compliance to the facility policy. assuring that each resident's electronic medication administration record prompts Nurses to obtain the vital signs required for each medication. Corrections will be done as necessary. As new orders are written the Head nurses will review every order for accuracy in the EMAR and to assure that the pronpts for vital signs have been entered correctly into the EMAR as well. The facility will explore adding a feature to the Electronic MAR to prompt/remind Nurses to document symptoms. treatments. recheck Blood glucoses and notify physician for hypo/hyperglycemic episodes. The facility's Nursing Administration will continue to audit Blood Glucose monitoring through frequent observation of MARs for hypo/hyperglycemic episodes as well as the review the clinical record for documentation of symptoms. treatment. rechecks of blood glucose and notification of physician/NP. 3. The facility will conduct an in-service for Licensed Nursing staff in regards to "Documentation of Required Vital Signs" and "Blood Glucose Monitoring: Treatment and Documentation of Hypo/Hyperglycemic Episodes". This in-service will be conducted by the Staff Development Coordinator. ADON and Head Nurses. The in-services will be conducted during the weeks between July 25 and August 12. 2011. 4. The facility will conduct a Quality Assurance/Improvement audit regarding "Documentation of Required Vital Signs" and "Blood Glucose Monitoring: Treatment and Documentation of	08/12/11 8/27/11

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			Hypo/Hyperglycemic Episodes". This study will be conducted no less than quarterly x 1 year beginning the 3rd quarter of 2011. This study will be completed during Nursing Administration's "In Search of Excellence" floor audits. The medication administration and clinical records of ten residents will be audited for documentation of required Vital Signs and /or Sliding Scale Insulin Blood Glucose monitoring to determine that facility Nurses are following policies and procedures. These audits will be conducted by the DON and/or ADON, Staff Development Coordinator, MDS Nurse Supervisor, Falls Prevention Nurse and Clinical Record Compliance Nurse. The results of this audit will be presented to the QA/I committee at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Asst Director of Nursing, Clinical Record Compliance Nurse, Dieticians, Rehab Director, Social Service Directors, Food Service Director, Falls Prevention Nurse/Coordinator, Housekeeping Directors, Laundry Director, Bookkeeping Director, and other staff invited to observe and participate.	